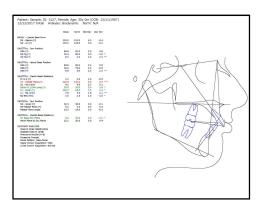


## **CEPHALOMETRIC ANALYSIS REQUEST FORM**





Patient Name:	Male Female
Patient DOB:	Date records made:
	•

Email your cephalometric x-ray to: trace@cephanalysis.com
Mail your original cephalometric x-ray to: D.E.T. · 11424 Cherisse Dr. · Austin, TX 78739 USA

## **CEPHALOMETRIC ANALYSIS REQUESTED (Please circle all analyses needed): ABO Biodynamic Biork** Burstone Clark **COGS** DiPaulo Downs **Eastman** Harvold Kois McGann McLaughlin McNamara **Modified Steiner** Owen Block **POS** Ricketts Steiner Rondeau Sassounni Tweed V.T.O Holdaway Wits \*custom analyses available free of charge I WOULD LIKE TO: Email my cephalometric x-ray for analysis \$39.00 U.S. Mail my cephalometric x-ray for analysis \$45.00 U.S. Superimposition in addition to ceph analysis \$25.00 U.S. Organize patient records- Photos, Models and X-rays \$26.00 U.S. \*Request for 24hr service-additional fee \$10.00 U.S. Payment to D.E.T. must be included with records and order form Total: \$ U.S. Name: Address: City: State/Province: Zi Phone: ( ) Fax: ( ) Email: Zip/Postal Code: I will pay by: Check (enclosed-mailed ceph only) MC Visa Amex Amount Payable to D.E.T.: \$\_\_\_\_ Acct. Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ 3-4 digit security code: \_\_\_\_